IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

September 13, 2007

Philip Herink, Administrator
8050 Northview Street
Boise, Idaho 83704

Provider #134009

Dear Mr. Herink:

On **August 30, 2007**, a Complaint Investigation was conducted at Sunhealth Behavioral Health System. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003167

Allegation #1: The hospital does not work with patients' families in finding alternative facilities prior to discharge.

Findings: An unannounced visit was made to the hospital on 8/30/07. Five clinical records and hospital policies were reviewed. Additionally, staff were interviewed.

The hospital's "SOCIAL SERVICES DISCHARGE AND AFTERCARE OF PATIENTS" policy stated, the hospitals goal was "to provide patients with ongoing discharge planning from their admission to their discharge and aftercare treatment appropriate to their needs." Further, the policy stated, "Requirements for discharge for each patient shall be developed by the interdisciplinary treatment team. The development of an initial discharge plan will begin with the formulation of the initial treatment plan which will be completed within 24 hrs. of the patient's admission. The discharge criteria shall be commensurate with the presenting problems and bases upon medical, psychiatric, and psychological evaluations. Re-evaluation of the discharge plan plan based on the initial treatment plan shall occur with the formulation of the patient's comprehensive treatment plan and will be reassessed throughout the patients hospitalization and will become more detailed as more information is obtained through interdisciplinary evaluations based on the patient's global situation.

Final discharge/aftercare planning shall occur when the interdisciplinaries treatment team agrees that the patient is nearing completion of his/her inpatient goals and objectives. An inherent component of discharge planning is the patient and/or family's input which shall reflect his or her progress and plans for continuing treatment or supportive services after discharge." The hospital's "REFERRAL SOURCES" policy stated, "Discharge referral planning is coordinated by the assigned case manager in conjunction with the primary physician, nursing, activities personnel and other members of the treatment team. The assigned case manager will consult with the patient, the patients family when applicable, and other members of the treatment team to explore what services are desirable and available."

Of the five records reviewed on 8/30/07 all five records documented in treatment meeting notes, social worker notes and nursing notes complete adherence to above policies. The records documented that there was family involvement throughout each of the patient's care and discharge planning. Further, it was documented that family's were encouraged to participate and exercised their right. Additionally, the patient's records documented that multiple aftercare facilities were contacted per families requests and the hospital entertained all requests.

On 8/30/07 at 12:10 PM, two social worker's that participate with discharge planning, stated they always involve the patient's family in the treatment planning process and discharge planning process and will pursue all family requests to the best of their abilities.

The allegation was unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation on 8/30/07.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: The hospital lost patient's clothing.

Findings: Five clinical records and hospital policies were reviewed. Additionally, staff were interviewed.

The hospital's "INVENTORY OF PERSONAL EFFECTS" policy stated, "All personal items brought to the hospital by the patient or for the patient will be catalogued an the Inventory of Personal Effects Form... Have patient or patient's representative review the list as preparation is made for discharge. The items are to be checked off in the presence of the patient or patient's representative. Have the patient/legal representative sign the form upon initial logging of items and after items are returned at the time of discharge. New items brought after admission are to be added under 'Acquired after original entry'."

Of the five records reviewed on 8/30/07 all five records documented complete adherence to above policies. All five records contained a "Inventory of Personal Effects". Al patients' personal items that were brought to the hospital were catalogued and the patients' legal representatives signed the form upon initial logging in of items and after the items were returned thus certifying their accuracy.

On 8/30/07 at 10:35 AM, the Director of Nursing and the Admission Coordinator confirmed that all patients' personal items brought into to the hospital were catalogued on the "Inventory of Personal Effects" form. They said that the patient or the patient's legal representative signed the form upon initial logging of items and after items are returned at the time of discharge.

The allegation was unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation on 8/30/07.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient was not allowed to wear their hearing aide.

Findings: Five clinical records were reviewed and staff were interviewed.

One patient's record documented an elderly male who was admitted to the hospital on 7/12/07 and was discharged on 7/25/07. The patient's record contained nursing notes that documented the patient often "refused cares," to include the assistance with his hearing aide. The patient's record also contained treatment team meeting notes that documented that this problem was discussed with the patient's family. It was ordered by the physician that when the patient refused to wear his hearing aide a family member was to be notified. The family member could then come in and assist the patient with his hearing aide.

On 8/30/07 at 11:25 AM, an aide that had worked with the patient stated, the patient would often refuse assistance with his hearing aide and at times a family member would come in and assist the patient. However, at times, the family member was unable to get the patient to wear his hearing aide also.

Two other records reviewed documented that each patient was assisted daily by staff with their hearing aides.

The allegation was unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation on 8/30/07.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw